

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9189

CERTIFICATE OF DEATH

09182

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>3 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 PALPH ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EFFIE MAY BARBER</u> First Middle Last		4. DATE OF DEATH <u>9-28-56</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONARD FRIZZELL</u>		14. MOTHER'S MAIDEN NAME <u>ALICE CARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-161579</u>	
17. INFORMANT <u>LEWIS M. BARBER</u> Address <u>77 Palph St. Westminster, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio-vascular renal disease with Hypertension</u> DUE TO (c) <u>Obesity for some years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity for some years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9-25-56</u> <u>9-24-56</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-24</u> , 19 <u>56</u> , to <u>9-28</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9-28</u> , 19 <u>56</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Billingslea</u> M.D. <u>Westminster, Md.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>C. H. Billingslea</u> <u>Westminster, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-2-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SMALLWOOD MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Bankard</u> ADDRESS <u>Westminster, MD</u>		24a. REC'D BY REGISTRAR DATE <u>10-2-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

BUREAU V. S.

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9194 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09183

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>5-yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BENEDICT</u> First Middle Last 4. DATE OF DEATH <u>Sept 25 1956</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>unknown</u> 9. AGE (In years last birthday) <u>about 78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Laborer</u> 13. FATHER'S NAME <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harm</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs Shipley</u> Address <u>Manchester Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		DATE SIGNED <u>9/25/56</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cath. Westminster Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Stipton</u>		ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Sept 30 56</u>			
24b. REGISTRAR'S SIGNATURE <u>W. H. P. Denner</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

3 OCT 3 1956

RECEIVED

9195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 N. MAIN ST				d. STREET ADDRESS 101 N. MAIN ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARY MATRANGOLO Bellusci				4. DATE OF DEATH Month Day Year Sept 9 1956			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 5, 1898	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME BIGGIO MATRANGOLO				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. —		17. INFORMANT Address Nick Bellusci HAMPSTEAD Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO (b) Chronic Myocarditis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH Suddenly
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from March 2, 1946 to Sept 9, 1956 , that I last saw the deceased alive on August 30, 1956 , and that death occurred at 8 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph E. Bush M.D.				ADDRESS (Street, city or town, state) Hampstead Md			
DATE SIGNED 9/8/56							
PHYSICIAN'S NAME (Type) Joseph E. Bush MD				HAMPSTEAD MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9-12-56		22c. NAME OF CEMETERY OR CREMATORY St John's Catholic Westminster Md		22d. LOCATION (City, town, or county) (State) Westminster Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edw A Tipton				ADDRESS Hampstead Md		24a. REC'D BY REGISTRAR DATE 9/10/56	
24b. REGISTRAR'S SIGNATURE Henry R. Lewis							

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CERTIFICATE OF DEATH

Coroner

Hampton

35 yrs

Hampton

24

101 N. Main St

MARY

MATTHEW B. BLOOM

2004

X

MAY 2 1904

Female white

Home

ITALY

U.S.A.

Richard Matthew

UNKNOWN

101 N. Main St

Acute Coronary Occlusion

Chronic Myocarditis

BUREAU V. S.

SEP 13 1904

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09185

9196

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4 years 4 months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2 d. STREET ADDRESS 417 E. Chase st. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Frances Last Bond		4. DATE OF DEATH Month 9 - Day 1 - Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-92
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 1 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Timothy Shanahan		14. MOTHER'S MAIDEN NAME Margaret Roche	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unk.	
17. INFORMANT Mrs. George E. Bond (Husband)		Address 417 E. Chase st. Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Stenosis 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia Bilateral, Pre-senile Psychosis.			
INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-2 , 1956 , to 9-1 , 1956 , that I last saw the deceased alive on 9-1 , 1956 , and that death occurred at 5.30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9-2-56	
PHYSICIAN'S NAME (Type) Agustin del Campo.		Springfield State Hospital.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-5-56	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 E. Paul St.		24a. REC'D BY REGISTRAR 9-2-56	
24b. REGISTRAR'S SIGNATURE C. Harry Allen			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Smith		Male		45		1956		Home	
Cause of Death		Manner of Death		Occupation		Residence		Burial Place	
Heart Disease		Natural		Teacher		Baltimore, Md.		Catholics	
Physician's Signature		Physician's Name		Physician's Address		Physician's Phone		Physician's License No.	
[Signature]		John A. Smith		123 Main St.		555-1234		12345	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's Phone		Medical Examiner's License No.	
[Signature]		John A. Smith		123 Main St.		555-1234		12345	
Coroner's Signature		Coroner's Name		Coroner's Address		Coroner's Phone		Coroner's License No.	
[Signature]		John A. Smith		123 Main St.		555-1234		12345	

BUREAU A. 1

SEP 5 1956

RECEIVED

9190

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
c. LENGTH OF STAY IN 1b 61 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 224 E. Main Street				d. STREET ADDRESS 224 E. Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Henry Bowers				4. DATE OF DEATH September 25 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Com.		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Bowers				14. MOTHER'S MAIDEN NAME Lucinda Frock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 226-03-6312		17. INFORMANT Mrs. Wm. H. Bowers Address Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Prostate & Liver 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (chr) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from June , 19 56 , to Sept. 25 , 19 56 , that I last saw the deceased alive on Sept 25 , 19 56 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 103 E. Main DATE SIGNED _____							
ACTUAL SIGNATURE W. C. Jennette M.D.							
PHYSICIAN'S NAME (Type) W. C. Jennette, M.D.				103 E. Main St. Westminster, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 56		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley		22d. LOCATION (City, town, or county) (State) Pleasant Valley, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR 9-28-56		24b. REGISTRAR'S SIGNATURE Harriet Miller	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Age		Sex	
Race		Marital Status	
Place of Birth		Usual Residence	
Cause of Death		Manner of Death	
Physician's Signature		Medical Examiner's Signature	
Date of Report		Time of Report	
Signature of Registrar		Signature of Coroner	
Signature of Burial Officer		Signature of Undertaker	
Signature of Funeral Home		Signature of Cemetery	
Signature of Health Officer		Signature of Board of Health	
Signature of State Department of Health		Signature of State Department of Health	

RECEIVED
OCT 1 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9197

CERTIFICATE OF DEATH

09187

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 15 yrs, 10 mos, 16 dys			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raspeburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Chesaco Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle DAVIS Last DAVIS				4. DATE OF DEATH Month September Day 27 Year 1956			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Eleasar Davis				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield Hospital records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Chronic pyelonephritis DUE TO (c) Mental Deficiency, Imbecility						INTERVAL BETWEEN ONSET AND DEATH days months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency, Imbecility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 to September 27, 1956 , that I last saw the deceased alive on September 27, 1956 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/28/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				ADDRESS Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-56		22c. NAME OF CEMETERY OR CREMATORY TRINITY CEMETERY		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James W. Gudzinski				ADDRESS 1407 Euteria Ave		24a. REC'D BY REGISTRAR DATE 1 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Sharp			

OCT 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09188

Reg. Dist. No. 80

9198

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN lb <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RURAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> <u>RURAL</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARISSA</u> First <u>MAY</u> Middle <u>DORSEY</u> Last 4. DATE OF DEATH <u>SEPT</u> Month <u>7</u> Day <u>1956</u> Year			5. SEX <u>F</u> 6. COLOR OR RACE <u>COL</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MAY 15 - 1956</u> 9. AGE (In years last birthday) _____ yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>NOT KNOWN</u> 14. MOTHER'S MAIDEN NAME <u>RUTHETTA DORSEY</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>RUTHETTA DORSEY</u> Address <u>NEW WINDSOR RURAL</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Infectious diarrhea</u> 772.0 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO _____ (c) _____ </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>3 mo.</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T Marsh</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>JAMES T MARSH</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-2-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u>		ADDRESS <u>New Windsor</u>		24a. REC'D BY REGISTRAR <u>9/3/56</u>			
24b. REGISTRAR'S SIGNATURE <u>Ernest P. ...</u>		24c. (City, town, or county) <u>LIBERTYTOWN</u> (State) <u>MD</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1000189XV4

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF CHIEF OF POLICE		24. SIGNATURE OF CHIEF OF FIRE DEPARTMENT		25. SIGNATURE OF CHIEF OF SANITARY DEPARTMENT	
26. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT		27. SIGNATURE OF CHIEF OF MENTAL HOSPITAL		28. SIGNATURE OF CHIEF OF EYE HOSPITAL		29. SIGNATURE OF CHIEF OF EAR, NOSE & THROAT HOSPITAL		30. SIGNATURE OF CHIEF OF DENTAL HOSPITAL	
31. SIGNATURE OF CHIEF OF DISPENSARY		32. SIGNATURE OF CHIEF OF PHARMACY		33. SIGNATURE OF CHIEF OF LABORATORY		34. SIGNATURE OF CHIEF OF RADIOLOGY		35. SIGNATURE OF CHIEF OF PATHOLOGY	
36. SIGNATURE OF CHIEF OF ANATOMY		37. SIGNATURE OF CHIEF OF PHYSIOLOGY		38. SIGNATURE OF CHIEF OF BOTANY		39. SIGNATURE OF CHIEF OF ZOOLOGY		40. SIGNATURE OF CHIEF OF AGRICULTURE	
41. SIGNATURE OF CHIEF OF FISHERIES		42. SIGNATURE OF CHIEF OF MINING		43. SIGNATURE OF CHIEF OF MANUFACTURES		44. SIGNATURE OF CHIEF OF COMMERCE		45. SIGNATURE OF CHIEF OF TRANSPORTATION	
46. SIGNATURE OF CHIEF OF EDUCATION		47. SIGNATURE OF CHIEF OF RELIGION		48. SIGNATURE OF CHIEF OF ARTS		49. SIGNATURE OF CHIEF OF SCIENCES		50. SIGNATURE OF CHIEF OF LETTERS	
51. SIGNATURE OF CHIEF OF MUSIC		52. SIGNATURE OF CHIEF OF THEATRE		53. SIGNATURE OF CHIEF OF CINEMA		54. SIGNATURE OF CHIEF OF RADIO		55. SIGNATURE OF CHIEF OF TELEVISION	
56. SIGNATURE OF CHIEF OF POSTAL SERVICE		57. SIGNATURE OF CHIEF OF TELEGRAPH		58. SIGNATURE OF CHIEF OF TELEPHONE		59. SIGNATURE OF CHIEF OF CABLE		60. SIGNATURE OF CHIEF OF AIR MAIL	
61. SIGNATURE OF CHIEF OF MARINE SERVICE		62. SIGNATURE OF CHIEF OF NAVY		63. SIGNATURE OF CHIEF OF ARMY		64. SIGNATURE OF CHIEF OF AIR FORCE		65. SIGNATURE OF CHIEF OF SPACE FORCE	
66. SIGNATURE OF CHIEF OF COAST GUARD		67. SIGNATURE OF CHIEF OF CUSTOMS		68. SIGNATURE OF CHIEF OF REVENUE		69. SIGNATURE OF CHIEF OF EXCISE		70. SIGNATURE OF CHIEF OF TARIFFS	
71. SIGNATURE OF CHIEF OF PATENTS		72. SIGNATURE OF CHIEF OF TRADE MARKS		73. SIGNATURE OF CHIEF OF COPYRIGHTS		74. SIGNATURE OF CHIEF OF DESIGN		75. SIGNATURE OF CHIEF OF INVENTIONS	
76. SIGNATURE OF CHIEF OF TRADE UNIONS		77. SIGNATURE OF CHIEF OF LABORERS		78. SIGNATURE OF CHIEF OF EMPLOYERS		79. SIGNATURE OF CHIEF OF MANAGERS		80. SIGNATURE OF CHIEF OF OWNERS	
81. SIGNATURE OF CHIEF OF SHAREHOLDERS		82. SIGNATURE OF CHIEF OF DEBTHOLDERS		83. SIGNATURE OF CHIEF OF CREDITORS		84. SIGNATURE OF CHIEF OF SUPPLIERS		85. SIGNATURE OF CHIEF OF CUSTOMERS	
86. SIGNATURE OF CHIEF OF Vendors		87. SIGNATURE OF CHIEF OF RETAILERS		88. SIGNATURE OF CHIEF OF WHOLESALE		89. SIGNATURE OF CHIEF OF EXPORTERS		90. SIGNATURE OF CHIEF OF IMPORTERS	
91. SIGNATURE OF CHIEF OF FREIGHT		92. SIGNATURE OF CHIEF OF PASSENGERS		93. SIGNATURE OF CHIEF OF MAIL		94. SIGNATURE OF CHIEF OF CARGO		95. SIGNATURE OF CHIEF OF BAGGAGE	
96. SIGNATURE OF CHIEF OF LUGGAGE		97. SIGNATURE OF CHIEF OF CHECKS		98. SIGNATURE OF CHIEF OF TICKETS		99. SIGNATURE OF CHIEF OF RESERVATIONS		100. SIGNATURE OF CHIEF OF ITINERARIES	

BUREAU V. 2

SEP 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09189

9199

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b since 2-24-55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS ---			
3. NAME OF DECEASED (Type or print) First Grant Middle Ulysses S. Last DUBEL				4. DATE OF DEATH Month September Day 25 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1875	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Months — Days — Hours — Min. —	• IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Rocky Ridge, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Cornelius Dubel				14. MOTHER'S MAIDEN NAME Caroline Damuth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Sykesville, Md. Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO (b) Cerebrovascular accident DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis							INTERVAL BETWEEN ONSET AND DEATH 2 days 4 weeks more than 1 1/2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6 , 19 55 , to Sept. 24 , 19 56 , that I last saw the deceased alive on Sept. 24 , 19 56 , and that death occurred at 8:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Gross		ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 9/25/56	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 9-28-1956		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cem.		22d. LOCATION (City, town, or county) (State) Thurmont Fredk. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24b. REGISTRAR'S SIGNATURE C. Harry Keys	
24a. REC'D BY REGISTRAR SEP 1 1956							

BUREAU V. S.

OCT 1 1956

RECEIVED

9200

CERTIFICATE OF DEATH

09190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dora Middle Ducson Last Ducson		4. DATE OF DEATH Month 9 Day 29 Year 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (Unknown) 1891
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas or Tom Johnson		14. MOTHER'S MAIDEN NAME Alice (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Dora Melvin		Address 1034 Aisquith St. Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Tuberculosis of the left Carpal bones			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-30 , 19 56 , to 9-29 , 19 56 , that I last saw the deceased alive on 9-29 , 19 56 , and that death occurred on 8-30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE T.F. Vestal		M.D. Henryton, Md.	
PHYSICIAN'S NAME (Type) T.F. Vestal, M. D.		Henryton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Oct 3	22c. NAME OF CEMETERY OR CREMATORY not known	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hester		24a. REC'D BY REGISTRAR DATE 10-1-56	
24b. REGISTRAR'S SIGNATURE Albert R. Swankhouse			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9201

CERTIFICATE OF DEATH

Reg. Dist. No.

09191

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1mo.; 27 days.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 23 E. Patrick Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katye Dyer		4. DATE OF DEATH Month Day Year September 9 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1871
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Ranneberger		14. MOTHER'S MAIDEN NAME Martha -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome; senility with psychosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 19 56 , to Sept. 9, 19 56 , that I last saw the deceased alive on Sept. 9, 19 56 , and that death occurred at 6:00P. M. from the causes and on the date stated above. Agustin del Campo ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/10/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-56	
22c. NAME OF CEMETERY OR CREMATORY St. Charles		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Esteban		24a. REC'D BY REGISTRAR DATE 9-10-56	
ADDRESS Frederick, Md.		24b. REGISTRAR'S SIGNATURE C. H. H. H.	

SEP 13 1956

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9202 CERTIFICATE OF DEATH

10150 74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 2234 N. Calvert St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle Chester Last EBY		4. DATE OF DEATH Month September Day 4 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1890
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter - carpenter		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME James Eby		14. MOTHER'S MAIDEN NAME Fannie -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis with parkinsonism DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH 4 days more than 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with psychotic reaction.) more than 3 yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. --- 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from June 22 , 19 53 , to Sept. 4 , 19 56 , that I last saw the deceased alive on Sept. 4 , 19 56 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Maryland DATE SIGNED 9/5/56			
ACTUAL SIGNATURE Martin Gross M.D.		PHYSICIAN'S NAME (Type) Martin Gross, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Embalmed		22b. DATE THEREOF 9/12/56	
22c. NAME OF CEMETERY OR CREMATORY W. of Mt. View - School		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR --- DATE 15 1956	
24b. REGISTRAR'S SIGNATURE C. Long Sharp			

RECEIVED: 1997 JAN 14

BUREAU V. 1

OCT 15 1956

RECEIVED

9203

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland				c. LENGTH OF STAY IN 1b 3 y. 8 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
				d. STREET ADDRESS 9708 Lawndale Drive			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Ferguson				4. DATE OF DEATH Month Day Year Sept. 18 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1889		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry King				14. MOTHER'S MAIDEN NAME Mary Ella Caywood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary artery embolism. 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic rheumatic heart disease. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic depressive reaction, manic type							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-26 , 19 52 , to 9-18 , 19 56 , that I last saw the deceased alive on 9-18 , 19 56 , and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gertrud Souwenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/18/1956	
PHYSICIAN'S NAME (Type) Gertrud Souwenfeldt M.D.				Springfield State Hospital, Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/21/56		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 9-25-56	
				24b. REGISTRAR'S SIGNATURE C. Henry Turner			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF MINISTER

14. SIGNATURE OF CHURCH

15. SIGNATURE OF PARISH

16. SIGNATURE OF DISTRICT

17. SIGNATURE OF COUNTY

18. SIGNATURE OF STATE

19. SIGNATURE OF UNION

20. SIGNATURE OF WORLD

21. SIGNATURE OF UNIVERSE

22. SIGNATURE OF GOD

23. SIGNATURE OF HEAVEN

24. SIGNATURE OF EARTH

25. SIGNATURE OF FIRE

26. SIGNATURE OF WATER

27. SIGNATURE OF AIR

28. SIGNATURE OF SPIRIT

29. SIGNATURE OF MIND

30. SIGNATURE OF BODY

31. SIGNATURE OF SOUL

32. SIGNATURE OF FLESH

33. SIGNATURE OF BLOOD

34. SIGNATURE OF HAIR

35. SIGNATURE OF NAILS

36. SIGNATURE OF TEETH

37. SIGNATURE OF EYES

38. SIGNATURE OF EARS

39. SIGNATURE OF NOSE

40. SIGNATURE OF MOUTH

41. SIGNATURE OF THROAT

42. SIGNATURE OF LUNGS

43. SIGNATURE OF HEART

44. SIGNATURE OF LIVER

45. SIGNATURE OF SPLEEN

46. SIGNATURE OF PANCREAS

47. SIGNATURE OF STOMACH

48. SIGNATURE OF SMALL INTESTINE

49. SIGNATURE OF LARGE INTESTINE

50. SIGNATURE OF RECTUM

51. SIGNATURE OF UTERUS

52. SIGNATURE OF VAGINA

53. SIGNATURE OF PENIS

54. SIGNATURE OF TESTES

55. SIGNATURE OF PROSTATE

56. SIGNATURE OF BLADDER

57. SIGNATURE OF URETERS

58. SIGNATURE OF URETHRA

59. SIGNATURE OF VULVA

60. SIGNATURE OF CLITORIS

61. SIGNATURE OF LABIA

62. SIGNATURE OF PERINEUM

63. SIGNATURE OF ANUS

64. SIGNATURE OF RECTAL SACCUS

65. SIGNATURE OF HEMORRHOIDS

66. SIGNATURE OF FISSURE

67. SIGNATURE OF PILES

68. SIGNATURE OF BRUISES

69. SIGNATURE OF SCALDS

70. SIGNATURE OF BURNS

71. SIGNATURE OF FROSTBITE

72. SIGNATURE OF CELLULITIS

73. SIGNATURE OF Erysipelas

74. SIGNATURE OF Carbuncle

75. SIGNATURE OF Abscess

76. SIGNATURE OF Empyema

77. SIGNATURE OF Pyothorax

78. SIGNATURE OF Empyema

79. SIGNATURE OF Pyothorax

80. SIGNATURE OF Empyema

81. SIGNATURE OF Pyothorax

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94. SIGNATURE OF Empyema

95. SIGNATURE OF Pyothorax

96. SIGNATURE OF Empyema

97. SIGNATURE OF Pyothorax

98. SIGNATURE OF Empyema

99. SIGNATURE OF Pyothorax

100. SIGNATURE OF Empyema

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF MINISTER

14. SIGNATURE OF CHURCH

15. SIGNATURE OF PARISH

16. SIGNATURE OF DISTRICT

17. SIGNATURE OF COUNTY

18. SIGNATURE OF STATE

19. SIGNATURE OF UNION

20. SIGNATURE OF WORLD

21. SIGNATURE OF UNIVERSE

22. SIGNATURE OF GOD

23. SIGNATURE OF HEAVEN

24. SIGNATURE OF EARTH

25. SIGNATURE OF FIRE

26. SIGNATURE OF WATER

27. SIGNATURE OF AIR

28. SIGNATURE OF SPIRIT

29. SIGNATURE OF MIND

30. SIGNATURE OF BODY

31. SIGNATURE OF SOUL

32. SIGNATURE OF FLESH

33. SIGNATURE OF BLOOD

34. SIGNATURE OF HAIR

35. SIGNATURE OF NAILS

36. SIGNATURE OF TEETH

37. SIGNATURE OF EYES

38. SIGNATURE OF EARS

39. SIGNATURE OF NOSE

40. SIGNATURE OF MOUTH

41. SIGNATURE OF THROAT

42. SIGNATURE OF LUNGS

43. SIGNATURE OF HEART

44. SIGNATURE OF LIVER

45. SIGNATURE OF SPLEEN

46. SIGNATURE OF PANCREAS

47. SIGNATURE OF STOMACH

48. SIGNATURE OF SMALL INTESTINE

49. SIGNATURE OF LARGE INTESTINE

50. SIGNATURE OF RECTUM

51. SIGNATURE OF UTERUS

52. SIGNATURE OF VAGINA

53. SIGNATURE OF PENIS

54. SIGNATURE OF TESTES

55. SIGNATURE OF PROSTATE

56. SIGNATURE OF BLADDER

57. SIGNATURE OF URETERS

58. SIGNATURE OF URETHRA

59. SIGNATURE OF VULVA

60. SIGNATURE OF CLITORIS

61. SIGNATURE OF LABIA

62. SIGNATURE OF PERINEUM

63. SIGNATURE OF ANUS

64. SIGNATURE OF RECTAL SACCUS

65. SIGNATURE OF HEMORRHOIDS

66. SIGNATURE OF FISSURE

67. SIGNATURE OF PILES

68. SIGNATURE OF BRUISES

69. SIGNATURE OF SCALDS

70. SIGNATURE OF BURNS

71. SIGNATURE OF FROSTBITE

72. SIGNATURE OF CELLULITIS

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75. SIGNATURE OF Abscess

76. SIGNATURE OF Empyema

77. SIGNATURE OF Pyothorax

78. SIGNATURE OF Empyema

79. SIGNATURE OF Pyothorax

80. SIGNATURE OF Empyema

81. SIGNATURE OF Pyothorax

82. SIGNATURE OF Empyema

83. SIGNATURE OF Pyothorax

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86. SIGNATURE OF Empyema

87. SIGNATURE OF Pyothorax

88. SIGNATURE OF Empyema

89. SIGNATURE OF Pyothorax

90. SIGNATURE OF Empyema

91. SIGNATURE OF Pyothorax

92. SIGNATURE OF Empyema

93. SIGNATURE OF Pyothorax

94. SIGNATURE OF Empyema

95. SIGNATURE OF Pyothorax

96. SIGNATURE OF Empyema

97. SIGNATURE OF Pyothorax

98. SIGNATURE OF Empyema

99. SIGNATURE OF Pyothorax

100. SIGNATURE OF Empyema

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09193

9204

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1316 Poplar Grove St.	
3. NAME OF DECEASED (Type or print) First Herman Middle Fisher Last Fisher		4. DATE OF DEATH Month September Day 18 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/15/94
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Hair Cutting	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany	
13. FATHER'S NAME John Fisher		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Springfield Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myodardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH Days Days Years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with chronic alcoholism; Korsakow's Syndrome.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1950 , to Sept. 18, 1956 , that I last saw the deceased alive on Sept. 18, 1956 , and that death occurred at 2:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 9/19/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-21-56	
22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight		24a. REC'D BY REGISTRAR DATE 9-21-56	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE C. Harry	

ARIZONA STATE DEPARTMENT OF HEALTH—TULSA

SEP 24 1956

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b. COUNTY

3 Vol. 4

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Day 10 Year 1950

IF UNDER 1 YEAR	IF UNDER 24 HRS.
-----------------	------------------

Months	Days	Hours	Min.
--------	------	-------	------

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

Addie

GEORGE GILPIN

INTERVAL BETWEEN
ONSET AND DEATH

15 min

19. WAS AUTOPSY

PERFORMED?
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

(Slot)

DATE SIGNED _____

Springfield State Mass.

VALDIS AIZKRAVČKIS mēģināja šādu 11.09.1991.

(54-101)

24b. REGISTRAR'S SIGNATURE

REC'D BY REGISTRAR 240. REGISTRAR'S SIGNATURE
SEP 1 9 10 PM C. H. H. H. H.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
JACOB DINE		Male		83	
Date of Death		Place of Death		Cause of Death	
August 19, 1956		Home		Heart failure	
Time of Death		Occupation		Usual Residence	
10:00 AM		Farmer		Home	
Physician		Manner of Death		Burial	
Dr. J. H. Smith		Natural		Buried	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 5

SEP 13 1956

RECEIVED

1 1 M X 15 1 0 1 VS A15 (4) ISM 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 VS A15 (4) ISM 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9206

CERTIFICATE OF DEATH

09195

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>38yrs. 8mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS <u>Chapel Street (?)</u>							
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>---</u> Last <u>Goodwin</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Fersch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>244</u>		17. INFORMANT Address <u>Hospital records - Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of uterus with metastasis</u> <u>174x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Diabetes</u> (b) <u>Diabetes</u> DUE TO (c) <u>260x</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3yrs</u> <u>6yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>---</u> p. m. <u>---</u> 19 <u>56</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) <u>-----</u>				20g. (County) <u>-----</u>		20h. (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>2-14-</u> 19 <u>42</u> , to <u>9-27-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9-27-</u> 19 <u>56</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morrell N. Mastin</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>			
DATE SIGNED <u>9-28-56</u>							
PHYSICIAN'S NAME (Type) <u>Morrell N. Mastin, M.D.</u>				Springfield State Hospital, Sykesville,			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>10-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Henry Weir</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. DATE OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED	
17. MEDICAL HISTORY		18. SOCIAL HISTORY		19. FAMILY HISTORY		20. PRESENT ILLNESS		21. TREATMENT		22. PROGNOSIS		23. COMMENTS		24. SIGNATURE OF PHYSICIAN	

RECEIVED
 OCT 4 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9207

CERTIFICATE OF DEATH

09196

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 yr, 16 dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaither			
3. NAME OF DECEASED (Type or print) First JOHN Middle Robert Last HARDING				4. DATE OF DEATH Month September Day 26 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/81	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert A. Harding				14. MOTHER'S MAIDEN NAME Luella Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes <input checked="" type="checkbox"/> unknown <input type="checkbox"/>				16. SOCIAL SECURITY NO. Unk			
17. INFORMANT Springfield State Hospital records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sykesville				20g. (County) Howard		20h. (State) Md.	
21. I certify that I attended the deceased from September 10 19 55 to September 26 19 56 , that I last saw the deceased alive on September 26 19 56 , and that death occurred at 9:00 P. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 9/27/56							
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-56		22c. NAME OF CEMETERY OR SEPULTORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Straight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR C. Harry	
DATE 9-28-56				24b. REGISTRAR'S SIGNATURE C. Harry			

CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH-LANINGORE / 2

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>		<p>7. PLACE OF DEATH</p>		<p>8. CAUSE OF DEATH</p>		<p>9. MANNER OF DEATH</p>		<p>10. SIGNATURE OF REGISTRAR</p>		<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. NAME OF DECEASED</p>		<p>14. SEX</p>		<p>15. AGE</p>		<p>16. DATE OF BIRTH</p>		<p>17. PLACE OF BIRTH</p>		<p>18. DATE OF DEATH</p>		<p>19. PLACE OF DEATH</p>		<p>20. CAUSE OF DEATH</p>		<p>21. MANNER OF DEATH</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF DECEASED</p>		<p>24. SIGNATURE OF WITNESSES</p>	
<p>25. NAME OF DECEASED</p>		<p>26. SEX</p>		<p>27. AGE</p>		<p>28. DATE OF BIRTH</p>		<p>29. PLACE OF BIRTH</p>		<p>30. DATE OF DEATH</p>		<p>31. PLACE OF DEATH</p>		<p>32. CAUSE OF DEATH</p>		<p>33. MANNER OF DEATH</p>		<p>34. SIGNATURE OF REGISTRAR</p>		<p>35. SIGNATURE OF DECEASED</p>		<p>36. SIGNATURE OF WITNESSES</p>	
<p>37. NAME OF DECEASED</p>		<p>38. SEX</p>		<p>39. AGE</p>		<p>40. DATE OF BIRTH</p>		<p>41. PLACE OF BIRTH</p>		<p>42. DATE OF DEATH</p>		<p>43. PLACE OF DEATH</p>		<p>44. CAUSE OF DEATH</p>		<p>45. MANNER OF DEATH</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF WITNESSES</p>	
<p>49. NAME OF DECEASED</p>		<p>50. SEX</p>		<p>51. AGE</p>		<p>52. DATE OF BIRTH</p>		<p>53. PLACE OF BIRTH</p>		<p>54. DATE OF DEATH</p>		<p>55. PLACE OF DEATH</p>		<p>56. CAUSE OF DEATH</p>		<p>57. MANNER OF DEATH</p>		<p>58. SIGNATURE OF REGISTRAR</p>		<p>59. SIGNATURE OF DECEASED</p>		<p>60. SIGNATURE OF WITNESSES</p>	
<p>61. NAME OF DECEASED</p>		<p>62. SEX</p>		<p>63. AGE</p>		<p>64. DATE OF BIRTH</p>		<p>65. PLACE OF BIRTH</p>		<p>66. DATE OF DEATH</p>		<p>67. PLACE OF DEATH</p>		<p>68. CAUSE OF DEATH</p>		<p>69. MANNER OF DEATH</p>		<p>70. SIGNATURE OF REGISTRAR</p>		<p>71. SIGNATURE OF DECEASED</p>		<p>72. SIGNATURE OF WITNESSES</p>	
<p>73. NAME OF DECEASED</p>		<p>74. SEX</p>		<p>75. AGE</p>		<p>76. DATE OF BIRTH</p>		<p>77. PLACE OF BIRTH</p>		<p>78. DATE OF DEATH</p>		<p>79. PLACE OF DEATH</p>		<p>80. CAUSE OF DEATH</p>		<p>81. MANNER OF DEATH</p>		<p>82. SIGNATURE OF REGISTRAR</p>		<p>83. SIGNATURE OF DECEASED</p>		<p>84. SIGNATURE OF WITNESSES</p>	
<p>85. NAME OF DECEASED</p>		<p>86. SEX</p>		<p>87. AGE</p>		<p>88. DATE OF BIRTH</p>		<p>89. PLACE OF BIRTH</p>		<p>90. DATE OF DEATH</p>		<p>91. PLACE OF DEATH</p>		<p>92. CAUSE OF DEATH</p>		<p>93. MANNER OF DEATH</p>		<p>94. SIGNATURE OF REGISTRAR</p>		<p>95. SIGNATURE OF DECEASED</p>		<p>96. SIGNATURE OF WITNESSES</p>	
<p>97. NAME OF DECEASED</p>		<p>98. SEX</p>		<p>99. AGE</p>		<p>100. DATE OF BIRTH</p>		<p>101. PLACE OF BIRTH</p>		<p>102. DATE OF DEATH</p>		<p>103. PLACE OF DEATH</p>		<p>104. CAUSE OF DEATH</p>		<p>105. MANNER OF DEATH</p>		<p>106. SIGNATURE OF REGISTRAR</p>		<p>107. SIGNATURE OF DECEASED</p>		<p>108. SIGNATURE OF WITNESSES</p>	

BUREAU V. S.

OCT 1 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8,9 FilmG206 11-9-56 et
9208
CERTIFICATE OF DEATH

09197
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 18	
4. NAME OF DECEASED (Type or print) Anne Cecilia HOPKINS		4. DATE OF DEATH Month September Day 14 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879 12 7 December 4, 1874
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) File Clerk		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Hopkins Charles M. Hopkins		14. MOTHER'S MAIDEN NAME Catherine Hammer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Springfield State Hospital records.	
17. INFORMANT Springfield State Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Fracture of neck of right femur, reduced. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with generalized arteriosclerosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days Years: 14 days	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Unknown		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8/31/ 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Balto. City Md.	
21. I certify that I attended the deceased from 9/11/ 1956 , to 9/14/ 1956 , that I last saw the deceased alive on September 14, 1956 , and that death occurred at 1:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/14/56 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 17, 1956	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemt.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24a. REC'D BY REGISTRAR SEP 17 1956	
ADDRESS 3000 E. Baltimore St.		24b. REGISTRAR'S SIGNATURE C. Harry Neely	

CERTIFICATE OF DEATH

BUREAU V. S.

SEP 17 1956

RECEIVED

John A. Moran, 3000 E. Baltimore St., Baltimore, Md.

Sept 17, 1956

John A. Moran, 3000 E. Baltimore St., Baltimore, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9209
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Maryland</u>		c. LENGTH OF STAY IN 1b <u>2yrs. 10 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		15-17-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>7504 Holly Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Grace</u> Last <u>ISRAEL</u>		4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-90</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Charles S. Linthicum</u>		14. MOTHER'S MAIDEN NAME <u>Alice Purdum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>ISRAEL</u>		Address <u>Charles Israel 7504 Holly St. Takoma Park</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic brain syndrome, associated with</u> DUE TO <u>Circulatory disturbance with psychotic</u> (c) <u>reaction.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>7 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-5-53</u> , 19 <u>53</u> to <u>9-6-</u> 19 <u>56</u> , that I last saw the deceased alive on <u>9-6-56</u> , 19 <u>56</u> , and that death occurred at <u>10-40 A</u> M, from the causes and on the date stated above. <u>9-6-56</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>4 Grandview, Sykesville, Md.</u>			
ACTUAL SIGNATURE <u>Dr. Ilse Kamm</u> M.D. <u>Ilse Kamm</u>			
PHYSICIAN'S NAME (Type) <u>Ilse Kamm</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>9-8-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elle Hartman</u>		24a. REC'D BY REGISTRAR DATE <u>9-10-56</u>	
ADDRESS <u>Fathersburg Md.</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Edman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH-DEATH

CERTIFICATE OF DEATH

DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
1956		11:00 AM		HOME	
DECEASED'S NAME		SEX		AGE	
JOHN J. SMITH		MALE		65	
DECEASED'S ADDRESS		CITY		STATE	
1234 MAIN ST.		BALTIMORE		MD	
DECEASED'S OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
RETIRED		HEART DISEASE		NATURAL	
DECEASED'S MARITAL STATUS		DECEASED'S RACE		DECEASED'S RELIGION	
MARRIED		WHITE		CATHOLIC	
DECEASED'S BIRTH DATE		DECEASED'S BIRTH PLACE		DECEASED'S BIRTH COUNTRY	
1901		BALTIMORE		USA	
DECEASED'S FATHER'S NAME		DECEASED'S MOTHER'S NAME		DECEASED'S FATHER'S OCCUPATION	
JOHN J. SMITH		MARY J. SMITH		RETIRED	
DECEASED'S FATHER'S BIRTH DATE		DECEASED'S FATHER'S BIRTH PLACE		DECEASED'S FATHER'S BIRTH COUNTRY	
1880		BALTIMORE		USA	
DECEASED'S MOTHER'S BIRTH DATE		DECEASED'S MOTHER'S BIRTH PLACE		DECEASED'S MOTHER'S BIRTH COUNTRY	
1885		BALTIMORE		USA	
DECEASED'S FATHER'S DEATH DATE		DECEASED'S FATHER'S DEATH PLACE		DECEASED'S FATHER'S DEATH COUNTRY	
DECEASED'S MOTHER'S DEATH DATE		DECEASED'S MOTHER'S DEATH PLACE		DECEASED'S MOTHER'S DEATH COUNTRY	
DECEASED'S FATHER'S DEATH CAUSE		DECEASED'S FATHER'S DEATH MANNER		DECEASED'S FATHER'S DEATH PLACE	
DECEASED'S MOTHER'S DEATH CAUSE		DECEASED'S MOTHER'S DEATH MANNER		DECEASED'S MOTHER'S DEATH PLACE	
DECEASED'S FATHER'S DEATH DATE		DECEASED'S FATHER'S DEATH PLACE		DECEASED'S FATHER'S DEATH COUNTRY	
DECEASED'S MOTHER'S DEATH DATE		DECEASED'S MOTHER'S DEATH PLACE		DECEASED'S MOTHER'S DEATH COUNTRY	
DECEASED'S FATHER'S DEATH CAUSE		DECEASED'S FATHER'S DEATH MANNER		DECEASED'S FATHER'S DEATH PLACE	
DECEASED'S MOTHER'S DEATH CAUSE		DECEASED'S MOTHER'S DEATH MANNER		DECEASED'S MOTHER'S DEATH PLACE	

BUREAU V. B.

SEP 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 9210
 CERTIFICATE OF DEATH

09199

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Woodstock			
3. NAME OF DECEASED (Type or print) First James Middle Henry Last Jenkins				4. DATE OF DEATH Month September Day 16 Year 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-88	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Yach		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Hurley Jenkins			
14. MOTHER'S MAIDEN NAME Judy Smith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 003.0 Intestinal hemorrhage DUE TO intestinal gangrene due to tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) peritonitis DUE TO (c) Tuberculous empyema							INTERVAL BETWEEN ONSET AND DEATH 1 day years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Spt. 14 , 19 54 , to Spt. 16 , 19 56 , that I last saw the deceased alive on Spt. 15 , 19 56 , and that death occurred at 3:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED Spt. 16, 1956							
ACTUAL SIGNATURE Martin Gross				M.D. Sykesville, Md.			
PHYSICIAN'S NAME (Type) Martin Gross, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		9-19-56		Mt View		Howard Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight - Sykesville, Md.				24. REC'D BY REGISTRAR DATE 9-17-56		24b. REGISTRAR'S SIGNATURE C. Harry Weer	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 2

SEP 18 1956

RECEIVED

9211

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 38yrs. 4mos. 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 3004 Dillon Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle JONDO Last JONDO				4. DATE OF DEATH Month September Day 21 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 65 ? yrs.		IF UNDER 1 YEAR Months ? Days ? Hours ? Min. ?		IF UNDER 24 HRS. Months ? Days ? Hours ? Min. ?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes. Dementia Praecox, catatonic type. Mellitus.							
INTERVAL BETWEEN ONSET AND DEATH Years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1950 , to September 21, 1956 , that I lost saw the deceased alive on September 20, 1956 , and that death occurred at 6:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Walther H. Sonnenfeldt ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/21/56 PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sept. 25-56		Belair Mem. Garden		Belair Md. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connelly				ADDRESS 3500 Bank St.		24a. REC'D BY REGISTRAR DATE 25 1956	
				24b. REGISTRAR'S SIGNATURE Calvary Kears			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1911		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JUN 10 1956		BALTIMORE		MD		USA		USA	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		CITY		STATE		COUNTRY	
HIGH SCHOOL		METHODIST		NONE		-		-		-		-		-	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		JAN 15 1911		JAN 15 1911		BALTIMORE		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
-		-		-		-		-		-		-		-	
FATHER'S CITY		MOTHER'S CITY		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		MD		MD		USA		USA		BALTIMORE		BALTIMORE	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE		MOTHER'S STATE	
LABORER		HOUSEWIFE		JAN 15 1911		JAN 15 1911		BALTIMORE		BALTIMORE		MD		MD	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S STATE		MOTHER'S STATE	
-		-		-		-		-		-		MD		MD	
FATHER'S CITY		MOTHER'S CITY		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		MD		MD		USA		USA		BALTIMORE		BALTIMORE	

BUREAU V. S.

SEP 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9212 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09201

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Purcell</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u> d. STREET ADDRESS <u>Jacqueline St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>LEE</u> Middle <u>KEFAUVER</u> Last				4. DATE OF DEATH <u>SEPT</u> Month <u>8</u> Day <u>1956</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/23/1940</u>	
9. AGE (In years last birthday) <u>15</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Calvin Richard Kefauver</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Catherine Fogle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>210-38-1496</u>		17. INFORMANT <u>Mary C. Kefauver, Union Bridge, Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURE SKULL</u> <u>825X</u> DUE TO (b) <u>Automobile Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>				20c. TIME OF INJURY Month, Day, Year <u>9-8-1956</u> Hour a. m. <u>12:15</u> p. m. <u>—</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Uniontown Rd</u>		20f. (City or town) <u>Westminster</u>		(County) <u>Carroll</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James J. Marsh</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/8/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Winters Cem.</u>		22d. LOCATION (City, town, or county) <u>Carroll County</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Smith, Union Bridge Md</u> ADDRESS				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>9-11-56</u>				24c. REGISTRAR'S SIGNATURE <u>—</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 13 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: WILLIAM J. BROWN

DATE OF DEATH: SEP 10 1956

PLACE OF DEATH: HOME

AGE: 45

SEX: MALE

RACE: WHITE

EDUCATION: HIGH SCHOOL

OCCUPATION: CLERK

CAUSE OF DEATH: HEART DISEASE

DETAILS OF DEATH: HEART ATTACK

DATE OF BURIAL: SEP 12 1956

PLACE OF BURIAL: CATHOLIC CEMETERY

SIGNATURE OF EXAMINER: [Signature]

DATE OF SIGNATURE: SEP 13 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09202

9213

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City (12) 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1340 Crofton Road			
3. NAME OF DECEASED (Type or print) First LOUISA Middle ELIZABETH Last KENNEY				4. DATE OF DEATH Month September Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1873	
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Ymk	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Holtzner				14. MOTHER'S MAIDEN NAME Mary Batchler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) No		17. INFORMANT (Daughter) Address Mrs. Ida Kenney Council-1240 Crofton Rd., Balto. 12			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 443X DUE TO Chronic Hypertensive Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17.11 CBS Assoc. with metabolis disturbance, with senile psychosis						INTERVAL BETWEEN ONSET AND DEATH One (1) month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1955 , to September 15, 1956 , that I last saw the deceased alive on Sept. 15, 1956 , and that death occurred at 2:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Valdis Aizkrauklis M.D. DATE SIGNED 9/15/56							
ACTUAL SIGNATURE Valdis Aizkrauklis PHYSICIAN'S NAME (Type) Springfield State Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/18/1956		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Ruck				ADDRESS 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE 9-15-56	
24b. REGISTRAR'S SIGNATURE C. Harry Wilson							

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SEP 19 1956

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9214

CERTIFICATE OF DEATH

Reg. Dist. No. 09293

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27y, 11mos. 23da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle KOPOLSKI Last				4. DATE OF DEATH Month September Day 5 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1870 ?	
9. AGE (In years last birthday) ? 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 428.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy with mental deficiency. Bronchopneumonia.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to September 5, 1956 , that I last saw the deceased alive on September 5, 1956 , and that death occurred at 10:35A , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/5/56	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9/5/56		22c. NAME OF CEMETERY OR CREMATORY Catholic		22d. LOCATION (City, town, or county) (State) Bld. Frederick Rd	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Foley & Sons				ADDRESS		24. REC'D BY REGISTRAR SEP 7 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Hays			

BUREAU V. S.

SEP 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9215 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09204

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3201-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 1124 S. Robinson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Naomi Middle Grace Last KUNSKY				4. DATE OF DEATH Month September Day 15 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 20, 1918	
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Herman Redmann				14. MOTHER'S MAIDEN NAME Margaret Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-3948		17. INFORMANT Address Springfield State Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 322.0 DOCK Conditions, if any, which gave rise to immediate cause (b) Acute suppurative pancreatitis (c), stating the underlying cause lost. DUE TO Acute alcoholism							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute brain syndrome due to alcoholism							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James T. Marsh EXAMINER'S NAME (Type) James T. Marsh, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/20/56		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park.	
22d. LOCATION (City, town, or county) Baltimore Md.				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE C.F. Hoffmann				ADDRESS 3218 Hudson St (24)		24a. REC'D BY REGISTRAR SEP 19 1956	
24b. REGISTRAR'S SIGNATURE C. Harry Jones				DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 DOCTOR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. [illegible]		Male		35	
Date of Death		Place of Death		Cause of Death	
Sept 18, 1956		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Doctor		Signature of Informant		Signature of Registrar	
[illegible]		[illegible]		[illegible]	

RECEIVED
 SEP 18 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9216

CERTIFICATE OF DEATH

Reg. Dist. No. 09205

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b 2 mos., 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5700 Bradley Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NICKOLAS Middle GEORGE Last LAIOS				4. DATE OF DEATH Month 9 Day 5 Year 19 56			
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1864		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hat-cleaning		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Laios				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Record, Springfield State Hospital, Sykesville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease with psychosis						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/3 , 19 56 , to 9/5 , 19 56 , that I last saw the deceased alive on 9/5 , 19 56 , and that death occurred at 9:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/5/56							
ACTUAL SIGNATURE Julian Radzykewycz				PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/8/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladenburg md	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE SEP 10 1956		24b. REGISTRAR'S SIGNATURE C. Barry Corp	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3218

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BROWN		JANUARY 15, 1956	
AGE		SEX	
65		MALE	
RACE		RELIGION	
WHITE		METHODIST	
BIRTHPLACE		PLACE OF BIRTH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH	
RETIRED		HEART DISEASE	
MANNER OF DEATH		DATE OF BURIAL	
NATURAL		JANUARY 16, 1956	
PLACE OF BURIAL		CITY OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. BROWN		J. H. BROWN	

BUREAU V. 3

SEP 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09206

9217

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs; 11mos; 14da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2435 Lakeview Ave.	
3. NAME OF DECEASED (Type or print) Frank First LEVINSON Middle Lost		4. DATE OF DEATH Month September Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1886
9. AGE (In years lost, birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Yuk	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yuk	
17. INFORMANT Springfield Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchiectasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Chronic Brain Syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1952 , to September 20, 1956 , that I last saw the deceased alive on September 20, 1956 , and that death occurred at 8:40 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital	
DATE SIGNED 9/21/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-56	
22c. NAME OF CEMETERY OR CREMATORY Herring Run		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutaw Place	
24a. REC'D BY REGISTRAR DATE 9-21-56		24b. REGISTRAR'S SIGNATURE C. H. H. H.	

SEP 24 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 FilmG204 9-19-56 et

9218

CERTIFICATE OF DEATH

09207

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland				c. LENGTH OF STAY IN 1b 10mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7			
f. STREET ADDRESS Miss Florence Neal, Wetheredsville				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Emma Last Lilley				4. DATE OF DEATH Month 9 Day 10 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 5 Hours 15 Min.		IF UNDER 24 HRS. Months 8 Days 5 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.							
13. FATHER'S NAME Emanuel E. Pierce				14. MOTHER'S MAIDEN NAME Alice V. Triplett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ----		17. INFORMANT Mrs. John E. Johnson	
						2709 E. Federal St. Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 331x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Genl. Arterio Sclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 48 hours 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 7-9- , 1956 , to 10-10 , 1956 , that I last saw the deceased alive on 10-10 , 1956 , and that death occurred at 11:05 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE M. N. Mastin M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland			
DATE SIGNED Oct 11-56							
PHYSICIAN'S NAME (Type) Dr. M. N. Mastin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/14/56		22c. NAME OF CEMETERY OR CREMATORY Ward's Chapel Cem.		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balto				ADDRESS 17 Madison St		24a. REC'D BY REGISTRAR 131956	
				24b. REGISTRAR'S SIGNATURE C. Harry King			

A34

CERTIFICATE OF DEATH

Sample

BUREAU V. S.

SEP 13 1956

RECEIVED

9219

CERTIFICATE OF DEATH

09208

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER ALL HIS LIFE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTMINSTER RD #4</u>				d. STREET ADDRESS <u>OLD BALTIMORE BLVD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES A. LOCKARD</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 3 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 18, 1866</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM & INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JESSE LOCKARD</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET TURFLE</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>LIONEL LOCKARD, WESTMINSTER RD #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 yrs</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> to <u>Sept 3</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Sept 3</u> , 19 <u>56</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 N. Westminister</u> DATE SIGNED <u>9/14/56</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D.							
PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 6, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CARROLLTON CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLLTON CARROLL CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr.</u> ADDRESS <u>Westminister</u>				24a. REC'D BY REGISTRAR <u>DATE 9-8-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

SEP 10 1956

RECEIVED

9191

CERTIFICATE OF DEATH

09209

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 174 Penna. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Ann Last Massicot		4. DATE OF DEATH Month Sept. Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1870
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Westminster, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George A. Chrest		14. MOTHER'S MAIDEN NAME Jane Fowler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Mrs. Mary Eckard Address Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Decompensation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Renal Vascular DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 1st, 1956 to Sept. 7, 1956 , that I last saw the deceased alive on Sept. 7, 1956 , and that death occurred at 1870 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED			
ACTUAL SIGNATURE Charles R. Foutz M.D.			
PHYSICIAN'S NAME (Type) Charles R. Foutz, Md.		148 W. Main St. Westminster, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 19-10-56	22c. NAME OF CEMETERY OR CREMATORY St. John's Catholic	22d. LOCATION (City, town, or county) (State) Westminster, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 9-12-56	24b. REGISTRAR'S SIGNATURE Harriet Miller

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9151

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. 5

SEP 13 1956

RECEIVED

NAME OF REGISTRAR [Illegible]		NAME OF CLERK [Illegible]	
NAME OF WITNESS [Illegible]		NAME OF WITNESS [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09210
9220 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 18y; 8mos; 15days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anton MIKUS				4. DATE OF DEATH Month Day Year September 7, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 61 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY unk	
11. BIRTHPLACE (State or foreign country) Lithuania				12. CITIZEN OF WHAT COUNTRY? Lithuania			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Springfield Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal hemorrhage 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastro-intestinal neoplasm DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Weeks Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Schizophrenia, catatonia type; Bronchopneumonia. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 7, 1955 to September 7 1956 , that I last saw the deceased alive on September 6, 1956 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Agustin del Campo M.D. Springfield State Hospital 9/7/56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-56		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth A. Wright - Sykesville, Md.				24a. REC'D BY REGISTRAR DATE 9-10-56		24b. REGISTRAR'S SIGNATURE C. Harry Wee	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG-200-10

<p>1. Name of deceased: John Doe</p>		<p>2. Sex: Male</p>	
<p>3. Date of birth: 1910-01-01</p>		<p>4. Place of birth: John Doe, Maryland</p>	
<p>5. Date of death: 1955-09-11</p>		<p>6. Place of death: John Doe, Maryland</p>	
<p>7. Cause of death: Heart Disease</p>		<p>8. Manner of death: Natural</p>	
<p>9. Signature of physician: John Doe</p>		<p>10. Signature of registrar: John Doe</p>	
<p>11. Signature of informant: John Doe</p>		<p>12. Signature of witness: John Doe</p>	
<p>13. Signature of funeral director: John Doe</p>		<p>14. Signature of undertaker: John Doe</p>	
<p>15. Signature of cemetery: John Doe</p>		<p>16. Signature of burial: John Doe</p>	
<p>17. Signature of cremation: John Doe</p>		<p>18. Signature of other: John Doe</p>	
<p>19. Signature of other: John Doe</p>		<p>20. Signature of other: John Doe</p>	
<p>21. Signature of other: John Doe</p>		<p>22. Signature of other: John Doe</p>	
<p>23. Signature of other: John Doe</p>		<p>24. Signature of other: John Doe</p>	
<p>25. Signature of other: John Doe</p>		<p>26. Signature of other: John Doe</p>	
<p>27. Signature of other: John Doe</p>		<p>28. Signature of other: John Doe</p>	
<p>29. Signature of other: John Doe</p>		<p>30. Signature of other: John Doe</p>	
<p>31. Signature of other: John Doe</p>		<p>32. Signature of other: John Doe</p>	
<p>33. Signature of other: John Doe</p>		<p>34. Signature of other: John Doe</p>	
<p>35. Signature of other: John Doe</p>		<p>36. Signature of other: John Doe</p>	
<p>37. Signature of other: John Doe</p>		<p>38. Signature of other: John Doe</p>	
<p>39. Signature of other: John Doe</p>		<p>40. Signature of other: John Doe</p>	
<p>41. Signature of other: John Doe</p>		<p>42. Signature of other: John Doe</p>	
<p>43. Signature of other: John Doe</p>		<p>44. Signature of other: John Doe</p>	
<p>45. Signature of other: John Doe</p>		<p>46. Signature of other: John Doe</p>	
<p>47. Signature of other: John Doe</p>		<p>48. Signature of other: John Doe</p>	
<p>49. Signature of other: John Doe</p>		<p>50. Signature of other: John Doe</p>	
<p>51. Signature of other: John Doe</p>		<p>52. Signature of other: John Doe</p>	
<p>53. Signature of other: John Doe</p>		<p>54. Signature of other: John Doe</p>	
<p>55. Signature of other: John Doe</p>		<p>56. Signature of other: John Doe</p>	
<p>57. Signature of other: John Doe</p>		<p>58. Signature of other: John Doe</p>	
<p>59. Signature of other: John Doe</p>		<p>60. Signature of other: John Doe</p>	
<p>61. Signature of other: John Doe</p>		<p>62. Signature of other: John Doe</p>	
<p>63. Signature of other: John Doe</p>		<p>64. Signature of other: John Doe</p>	
<p>65. Signature of other: John Doe</p>		<p>66. Signature of other: John Doe</p>	
<p>67. Signature of other: John Doe</p>		<p>68. Signature of other: John Doe</p>	
<p>69. Signature of other: John Doe</p>		<p>70. Signature of other: John Doe</p>	
<p>71. Signature of other: John Doe</p>		<p>72. Signature of other: John Doe</p>	
<p>73. Signature of other: John Doe</p>		<p>74. Signature of other: John Doe</p>	
<p>75. Signature of other: John Doe</p>		<p>76. Signature of other: John Doe</p>	
<p>77. Signature of other: John Doe</p>		<p>78. Signature of other: John Doe</p>	
<p>79. Signature of other: John Doe</p>		<p>80. Signature of other: John Doe</p>	
<p>81. Signature of other: John Doe</p>		<p>82. Signature of other: John Doe</p>	
<p>83. Signature of other: John Doe</p>		<p>84. Signature of other: John Doe</p>	
<p>85. Signature of other: John Doe</p>		<p>86. Signature of other: John Doe</p>	
<p>87. Signature of other: John Doe</p>		<p>88. Signature of other: John Doe</p>	
<p>89. Signature of other: John Doe</p>		<p>90. Signature of other: John Doe</p>	
<p>91. Signature of other: John Doe</p>		<p>92. Signature of other: John Doe</p>	
<p>93. Signature of other: John Doe</p>		<p>94. Signature of other: John Doe</p>	
<p>95. Signature of other: John Doe</p>		<p>96. Signature of other: John Doe</p>	
<p>97. Signature of other: John Doe</p>		<p>98. Signature of other: John Doe</p>	
<p>99. Signature of other: John Doe</p>		<p>100. Signature of other: John Doe</p>	

BUREAU V. 3

SEP 11 1956

RECEIVED

9221

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Carroll County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Westminster		d. STREET ADDRESS 7 Westminster St	
3. NAME OF DECEASED (Type or print) First Charles Middle E. Last Monath		4. DATE OF DEATH Month September Day 2 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 5 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Cranberry, Maryland	
11. BIRTHPLACE (State or foreign country) Cranberry, Maryland		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Christian Monath		14. MOTHER'S MAIDEN NAME Krenzer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-22-9639	
17. INFORMANT Mrs. Marian Monath, Manchester, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension + arteriosclerosis DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1st cerebral hemorrhage Jan. 1956		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-56 , 19 56 , to 9-2- , 19 56 , that I last saw the deceased alive on 9-1- , 19 56 , and that death occurred at 3 A. M, from the causes and on the date stated above. ADDRESS (Street, City or town, State) Reisterstown Md DATE SIGNED 9-3-56			
ACTUAL SIGNATURE James G. Saffell M.D.		DATE SIGNED 9-3-56	
PHYSICIAN'S NAME (Type) JAMES G. SAFFELL		ADDRESS Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9-5-56	22c. NAME OF CEMETERY OR CREMATORY St. Davids Cemetery	22d. LOCATION (City, town, or county) (State) York County, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin		24a. REC'D BY REGISTRAR SEP 6 1956	
ADDRESS Manchester, Md		24b. REGISTRAR'S SIGNATURE Mrs. J. B. Dennis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

SEP 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9222 CERTIFICATE OF DEATH

09212

Reg. Dist. No. 80

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CARROLL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>NEW WINDSOR</u>		<u>YEARS</u>		TOWN <u>NEW WINDSOR</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MAIN STREET</u>				STREET ADDRESS (If rural give location) <u>MAIN STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ALICE</u> (Middle) <u>MARIE</u> (Last) <u>PATTERSON</u>				(Month) <u>SEPT</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>2/11/1894</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>ROBERT JONES</u>				14. MOTHER'S MAIDEN NAME <u>CORA DORSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-16-4940</u>		17. INFORMANT & ADDRESS <u>ARTHUR PATTERSON New Windsor Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 years.	
201X IMMEDIATE CAUSE (A) <u>Hodgkins Disease</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 31</u> , 19 <u>56</u> , to <u>Sept 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Aug 31</u> , 19 <u>56</u> , and that death occurred at <u>8:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. Marshall</u>				ADDRESS (Street, city, town, state) <u>Baltimore Md</u>		DATE SIGNED <u>9/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		LOCATION (City, town, or county) (State) <u>FREDERICK CO. MD.</u>	
24. REC'D BY REGISTRAR <u>Edward Boudier</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>OD Hartzler & Sons</u>		ADDRESS <u>New Windsor</u>	
DATE <u>Sept 20 1956</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09213

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First John Middle Petrakov Last Petrakov		4. DATE OF DEATH Month 9 Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 51 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME ? Petrakov		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self from tree.	
20c. TIME OF INJURY Hour o. m. p. m. Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Field		20f. (City or town) (County) (State) Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Paul F. Guerlin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Paul F. Guerlin, M.D.		DATE SIGNED 9/14/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-18-56	
22c. NAME OF CEMETERY OR CREMATORY ST. ANDREW'S CEM		22d. LOCATION (City, town, or county) (State) GERMAN HILL RD., MD	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Geller		24a. REC'D BY REGISTRAR DATE 20 1956	
24b. REGISTRAR'S SIGNATURE C. Harry Van			

STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John	
Residence		Baltimore	
Place of Death		John's Home	
Date of Death		September 21, 1956	
Time of Death		10:30 AM	
Cause of Death		Hanging	
Manner of Death		Suicide	
Signature of Examiner		[Signature]	
Signature of Coroner		[Signature]	

Handed all from tree.

BUREAU V. R.

SEP 21 1956

RECEIVED

9224

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS - A - POWDER</u>				4. DATE OF DEATH Month Day Year <u>Sept 21 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30 - 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Ry Employee</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm H. Powder</u>				14. MOTHER'S MAIDEN NAME <u>Martha A. Wampler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Francis L Powder - Romney W. Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pulmonary Emphysema</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary fibrosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>6 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 20</u> 19 <u>56</u> to <u>Sept 21</u> 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 20</u> 19 <u>56</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Manchester Md</u> DATE SIGNED <u>9/21/56</u> ACTUAL SIGNATURE <u>W H Foard</u> M.D. <u>W H Foard</u> PHYSICIAN'S NAME (Type) <u>W. H. Foard M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Sept 24/56</u>		<u>Druid Ridge</u>		<u>Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edw O. Tipton Hampstead Md</u>				24a. REC'D BY REGISTRAR <u>Sept 21 - 56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs W R Souner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0283

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF CLERK</p>	
<p>17. SIGNATURE OF NOTARY</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. SIGNATURE OF CHIEF CLERK</p>		<p>20. SIGNATURE OF ASSISTANT CLERK</p>	
<p>21. SIGNATURE OF DEPUTY CLERK</p>		<p>22. SIGNATURE OF CLERK IN CHARGE</p>	
<p>23. SIGNATURE OF CLERK IN CHARGE</p>		<p>24. SIGNATURE OF CLERK IN CHARGE</p>	
<p>25. SIGNATURE OF CLERK IN CHARGE</p>		<p>26. SIGNATURE OF CLERK IN CHARGE</p>	
<p>27. SIGNATURE OF CLERK IN CHARGE</p>		<p>28. SIGNATURE OF CLERK IN CHARGE</p>	
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<p>35. SIGNATURE OF CLERK IN CHARGE</p>		<p>36. SIGNATURE OF CLERK IN CHARGE</p>	
<p>37. SIGNATURE OF CLERK IN CHARGE</p>		<p>38. SIGNATURE OF CLERK IN CHARGE</p>	
<p>39. SIGNATURE OF CLERK IN CHARGE</p>		<p>40. SIGNATURE OF CLERK IN CHARGE</p>	
<p>41. SIGNATURE OF CLERK IN CHARGE</p>		<p>42. SIGNATURE OF CLERK IN CHARGE</p>	
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<p>45. SIGNATURE OF CLERK IN CHARGE</p>		<p>46. SIGNATURE OF CLERK IN CHARGE</p>	
<p>47. SIGNATURE OF CLERK IN CHARGE</p>		<p>48. SIGNATURE OF CLERK IN CHARGE</p>	
<p>49. SIGNATURE OF CLERK IN CHARGE</p>		<p>50. SIGNATURE OF CLERK IN CHARGE</p>	
<p>51. SIGNATURE OF CLERK IN CHARGE</p>		<p>52. SIGNATURE OF CLERK IN CHARGE</p>	
<p>53. SIGNATURE OF CLERK IN CHARGE</p>		<p>54. SIGNATURE OF CLERK IN CHARGE</p>	
<p>55. SIGNATURE OF CLERK IN CHARGE</p>		<p>56. SIGNATURE OF CLERK IN CHARGE</p>	
<p>57. SIGNATURE OF CLERK IN CHARGE</p>		<p>58. SIGNATURE OF CLERK IN CHARGE</p>	
<p>59. SIGNATURE OF CLERK IN CHARGE</p>		<p>60. SIGNATURE OF CLERK IN CHARGE</p>	
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<p>67. SIGNATURE OF CLERK IN CHARGE</p>		<p>68. SIGNATURE OF CLERK IN CHARGE</p>	
<p>69. SIGNATURE OF CLERK IN CHARGE</p>		<p>70. SIGNATURE OF CLERK IN CHARGE</p>	
<p>71. SIGNATURE OF CLERK IN CHARGE</p>		<p>72. SIGNATURE OF CLERK IN CHARGE</p>	
<p>73. SIGNATURE OF CLERK IN CHARGE</p>		<p>74. SIGNATURE OF CLERK IN CHARGE</p>	
<p>75. SIGNATURE OF CLERK IN CHARGE</p>		<p>76. SIGNATURE OF CLERK IN CHARGE</p>	
<p>77. SIGNATURE OF CLERK IN CHARGE</p>		<p>78. SIGNATURE OF CLERK IN CHARGE</p>	
<p>79. SIGNATURE OF CLERK IN CHARGE</p>		<p>80. SIGNATURE OF CLERK IN CHARGE</p>	
<p>81. SIGNATURE OF CLERK IN CHARGE</p>		<p>82. SIGNATURE OF CLERK IN CHARGE</p>	
<p>83. SIGNATURE OF CLERK IN CHARGE</p>		<p>84. SIGNATURE OF CLERK IN CHARGE</p>	
<p>85. SIGNATURE OF CLERK IN CHARGE</p>		<p>86. SIGNATURE OF CLERK IN CHARGE</p>	
<p>87. SIGNATURE OF CLERK IN CHARGE</p>		<p>88. SIGNATURE OF CLERK IN CHARGE</p>	
<p>89. SIGNATURE OF CLERK IN CHARGE</p>		<p>90. SIGNATURE OF CLERK IN CHARGE</p>	
<p>91. SIGNATURE OF CLERK IN CHARGE</p>		<p>92. SIGNATURE OF CLERK IN CHARGE</p>	
<p>93. SIGNATURE OF CLERK IN CHARGE</p>		<p>94. SIGNATURE OF CLERK IN CHARGE</p>	
<p>95. SIGNATURE OF CLERK IN CHARGE</p>		<p>96. SIGNATURE OF CLERK IN CHARGE</p>	
<p>97. SIGNATURE OF CLERK IN CHARGE</p>		<p>98. SIGNATURE OF CLERK IN CHARGE</p>	
<p>99. SIGNATURE OF CLERK IN CHARGE</p>		<p>100. SIGNATURE OF CLERK IN CHARGE</p>	

BUREAU V. S.

SEP 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09215

9225

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll 085			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 yr. 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro			
				d. STREET ADDRESS Oak Hill, Woodsboro			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Horace Middle Daniel Last Radcliff				4. DATE OF DEATH Month 9 Day 30 Year 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/6/83	9. AGE (In years last birthday) 72 7/11 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store keeper				10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Daniel S. Radcliff				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Margaret Garver							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbances with cerebral arteriosclerosis with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 9-13- 19 55 to 9-30- 19 56 , that I last saw the deceased alive on 9-30-56 , 19 56 , and that death occurred at 8.45 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital.					
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 9-30-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Rocky Hill		22d. LOCATION (City, town, or county) (State) W. Woodsboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G.C. Barton, Walkersville, Md.				24a. REC'D BY REGISTRAR DATE 3 Oct. 1956		24b. REGISTRAR'S SIGNATURE C. Harry Kern	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Residence		Hospital		Physician	
Burial Place		Burial Date		Burial Time	
Signature of Registrar		Signature of Physician		Signature of Coroner	
Date of Registration		Date of Death		Date of Burial	
County		City		State	

BUREAU V. 8

OCT 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9226

CERTIFICATE OF DEATH

09216

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster				c. LENGTH OF STAY IN 1b 32 Years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gamber				d. STREET ADDRESS Gamber			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John William Reese				4. DATE OF DEATH Sept. 8 Month 8 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1876	
9. AGE (In years lost last day) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis W. Reese				14. MOTHER'S MAIDEN NAME Jane Coppersmith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 216-10-4865		17. INFORMANT Mrs. John W. Reese		Address Westminster, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) 2 yrs							INTERVAL BETWEEN ONSET AND DEATH 9-1-56 year 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-40 to 9-8-56 , that I last saw the deceased alive on 9-8-56 , and that death occurred at 6 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Staffell		M.D. Westminster, Md.		ADDRESS (Street, city or town, state) Westminster, Md.		DATE SIGNED 9-10-56	
PHYSICIAN'S NAME (Type) James G. Staffell		M.D. Westminster, Md.		ADDRESS (Street, city or town, state) Westminster, Md.		DATE SIGNED 9-10-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 56		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		22d. LOCATION (City, town, or county) (State) Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers Jr.				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE 9-11-56	
						24b. REGISTRAR'S SIGNATURE Harriet Muller	

CERTIFICATE OF DEATH

1936

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
John William		Male		35		1901		Boston, Mass.		Boston, Mass.		Heart Disease		1936		Boston, Mass.		10:00 AM		[Signature]		[Signature]		[Signature]	
Occupation		Marital Status		Color		Height		Weight		Complexion		Education		Religion		Previous Illnesses		Previous Injuries		Previous Operations		Previous Habits		Previous Occupations	
Carpenter		Married		White		5' 8"		170 lbs		Fair		High School		Roman Catholic		None		None		None		None		None	
Date of Death		Place of Death		Time of Death		Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Pharmacist		Signature of Nurse	
1936		Boston, Mass.		10:00 AM		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
SEP 13 1956
BUREAU V. &

CERTIFICATE OF DEATH

Reg. Dist. No.

9227

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 1 yr. 2 mos.		d. STREET ADDRESS 1054 Lerew Way	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last Reuttinger		4. DATE OF DEATH Month Sept. Day 6 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-22-90
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Lubbehusen	
14. MOTHER'S MAIDEN NAME Susana Cooper		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk	
16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 260x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Chronic hypertension (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH one-half hour Several years Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Involutional Psychotic Reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-13 , 19 55 , to 9-6 , 19 56 , that I last saw the deceased alive on 9-6 , 19 56 , and that death occurred at 9:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Valdis Aizkrauklis		ADDRESS (Street, city or town, state) DATE SIGNED Springfield State Hospital 9/6/56	
PHYSICIAN'S NAME (Type) Valdis Aizkrauklis		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-10-56	22c. NAME OF CEMETERY OR CREMATORY St Peter's	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc.		ADDRESS 1217 St Paul St.	
24a. REC'D BY REGISTRAR 5-6-56		24b. REGISTRAR'S SIGNATURE C. Henry Weir	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAXLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APR 4 1968		MEMPHIS		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		RELIGION		RACE	
ATTORNEY		HIGH SCHOOL		METHODIST		WHITE	
SIGNED AND SWORN TO		CERTIFIED TRUE		DATE		PLACE	
JAMES EARL RAY		JAMES EARL RAY		APR 4 1968		MEMPHIS	
TESTED BY		TESTED BY		TESTED BY		TESTED BY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. 2

SEP 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9228
CERTIFICATE OF DEATH

09219
74

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carrol MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 27½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 3736 Gough St.							
3. NAME OF DECEASED (Type or print) Elizabeth First Middle Last Schultz				4. DATE OF DEATH Month September Day 14 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-11-1878		9. AGE (In years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland, USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Groskote				14. MOTHER'S MAIDEN NAME Maggie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin Schultz, 3504 Fleet St., Balto 24			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS ass with Disturb. of Metabolism, Growth or Nutr. with Senile Brain Disease							INTERVAL BETWEEN ONSET AND DEATH 17 hrs years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 2 , 19 54 , to Sep 13 , 19 56 , that I last saw the deceased alive on Sep 13 , 19 56 , and that death occurred at 2:40 A . M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 9-14-56 ACTUAL SIGNATURE Irene L. Hitchman , M.D. Sykesville, Md. PHYSICIAN'S NAME (Type) Irene L. Hitchman, MD Sykesville, Md. 9.14.56							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Sep. 17-56		Morland Memorial		Taylor Ave. Balto Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Connolly				ADDRESS 4186 Eastern Blvd.		24a. REC'D BY REGISTRAR SEP 17 1956	
						24b. REGISTRAR'S SIGNATURE C. Harry Marx	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL HOME

DATE OF CREMATION

PLACE OF CREMATION

NAME OF CREMATION HOME

DATE OF REINTERMENT

PLACE OF REINTERMENT

NAME OF REINTERMENT HOME

DATE OF REINTERMENT

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NAME OF REINTERMENT HOME

BUREAU V. 3

SEP 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09220

9229

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 8½ yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2723 Oakley Ave. City Hospital Infirmary			
3. NAME OF DECEASED (Type or print) First Clarence Middle Edward Last Scott				4. DATE OF DEATH Month Spt. Day 3 Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1888 June 4	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
13. FATHER'S NAME Roger Scott				14. MOTHER'S MAIDEN NAME Rosa Candle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Records of Springfield State Hospital Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with cerebral arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH seconds over 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				20g. (County) _____		20h. (State) _____	
21. I certify that I attended the deceased from Aug. 12 , 19 48 , to Spt. 3 , 19 56 , that I last saw the deceased alive on Spt. 2 , 19 56 , and that death occurred at 2:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hosp. 9-3-56 PHYSICIAN'S NAME (Type) Martin Gross, M.D. Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/56		22c. NAME OF CEMETERY OR CREMATORY Maury Cemetery		22d. LOCATION (City, town, or county) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons				ADDRESS 1900 Futaw Place		24a. REC'D BY REGISTRAR DATE 9-3-56	
				24b. REGISTRAR'S SIGNATURE C. Harry Ewen			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

SEP 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09221

9230

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY Balto. County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Virginia Last EDWARDS				4. DATE OF DEATH Month September Day 20 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1902	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arthur Edwards				14. MOTHER'S MAIDEN NAME Anna DeBruler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield State Hospital records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 605X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured urinary bladder DUE TO (c) Cystitis						INTERVAL BETWEEN ONSET AND DEATH Hours 4 wks. plus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Congenital atrial septal defect. Schizophrenic reaction, catatonic type.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 22, 1956 , to September 20, 1956 , that I last saw the deceased alive on September 20, 1956 , and that death occurred at 2:05 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital				DATE SIGNED 9/21/56	
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		SYKESVILLE, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 24-56		22c. NAME OF CEMETERY OR CREMATORY Canaan Cemetery		22d. LOCATION (City, town, or county) (State) Chase Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly Esq. m.d.				ADDRESS SEP 25 1956		24a. REC'D BY REGISTRAR C. Harry Deers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09222

9231

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b since 10-5-53	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3. NAME OF DECEASED (Type or print) First Chauncey Middle Maurice Last SMITH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 832 S. Bond Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month September Day 27 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1903
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR: Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet metal worker		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Levin J. Smith		14. MOTHER'S MAIDEN NAME Margaret Carew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records of Springfield State Hospital		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Central nervous system syphilis DUE TO (c) --- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis - years 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from Feb. 26 , 19 54 , to Sept. 27 , 19 56 , that I last saw the deceased alive on Sept. 27 , 19 56 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 9/28/56			
ACTUAL SIGNATURE Martin Gross		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Martin Gross, M. D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/21/56	
22c. NAME OF CEMETERY OR CREMATORY Trinity Cem		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Philip Horwig		ADDRESS 2024 Orleans	
24a. REC'D BY REGISTRAR 1		24b. REGISTRAR'S SIGNATURE C. Harry Sharp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9232

CERTIFICATE OF DEATH

09223

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 48yrs; 7mos; 3days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1100 S. Paca St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle E. Last SMITH				4. DATE OF DEATH Month September Day 23 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodworker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown John Smith				14. MOTHER'S MAIDEN NAME Unknown Louise Deitchman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. none -			
17. INFORMANT Springfield Hospital records.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease. DUE TO (c) Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Springfield State Hospital				20g. (County) Balto., Md.		20h. (State) Balto., Md.	
21. I certify that I attended the deceased from July 1, 1950 , to September 23, 1956 , that I last saw the deceased alive on September 23, 1956 , and that death occurred at 11:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt M.D.				DATE SIGNED 9/24/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				ADDRESS (Street, city or town, state) Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/56		22c. NAME OF CEMETERY OR CREMATORY Western Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS - Balto. 17, Md.				24a. REC'D BY REGISTRAR SEP 28 1956			
24b. REGISTRAR'S SIGNATURE C. Harry Heers							

ASH
800

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RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09224

9233 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Carroll		STATE Md.		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and give nearest town) Sykesville		LENGTH OF STAY (In this place) 6 days		CITY (If outside corporate limits, write RURAL and give nearest town) Glyndon, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Grand View Nursing Home				STREET ADDRESS (If rural give location) Glyndon Ave.			
3. NAME OF DECEASED (First) Rosamond (Middle) E. (Last) Smith				4. DATE OF DEATH (Month) Sept. (Day) 16 (Year) 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Aug. 18, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Art Teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Walsh Smith				14. MOTHER'S MAIDEN NAME Mary Elizabeth Leas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Ira Wales, Glyndon, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
2021 IMMEDIATE CAUSE (A) Lymphoblastoma						INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 7 mos.	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertensive C-V Disease						17 yrs.	
19a. DATE OF OPERATION 7-13-56		19b. MAJOR FINDINGS OF OPERATION Giant Follicular Lymphoblastoma				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.) none		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? none			
22. I hereby certify that I attended the deceased from 10-25, 1936, to 9-16, 1956, that I last saw the deceased alive on 9-12, 1956, and that death occurred at 8 A.M. from the causes and on the date stated above.							
SIGNATURE D. D. Caples				ADDRESS (Street, city, town, state) M.D. 6 Hanover Rd., Reisterstown, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF Sept. 18/56		NAME OF CEMETERY OR CREMATORY Druid Ridge	
24. REC'D BY REGISTRAR DATE 9-17-56				REGISTRAR'S SIGNATURE C. Harry Shaw		25. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.	
LOCATION (City, town, or county) Pikesville, Md.				DATE SIGNED 9-17-56			

RECEIVED

9192

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
c. LENGTH OF STAY IN <u>40 YRS.</u>				d. STREET ADDRESS <u>67 RALPH ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>67 RALPH ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>MAY</u> Last <u>SPENCER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 31-1912</u>		9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SPENCER</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA FLATER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>MRS HARVET PITTER WESTMINSTER MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis & Hypertension</u> DUE TO (c) <u>5420</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 53</u> , to <u>Sept 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md.</u> DATE SIGNED <u>9/23/56</u>			
PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SANDY MOUNT G.E.M.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. Bunkard & Son</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9-24-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Pitter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09226

9234

CERTIFICATE OF DEATH

Reg. Dist. No.

71

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linwood Rural</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Linwood</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary C. Spielman</u>				4. DATE OF DEATH Month Day Year <u>September 7, 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 27, 1882</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Nusbaum</u>			
15. WAS DECEASED IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Charles J. Spielman, Jr., Linwood, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>430.0</u> DUE TO <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1954</u> to <u>Sept 7, 1956</u> (at I last saw the deceased alive on <u>Sept 7, 1956</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kennerly Ave, Linwood, Md.</u> DATE SIGNED <u>9/8/56</u> ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D. PHYSICIAN'S NAME (Type) <u>E. Reese Wilkens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Winter's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Linwood, Carroll, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Margaret C. Foss</u> ADDRESS <u>Taneytown, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>9/9/56</u>		24b. REGISTRAR'S SIGNATURE <u>Margaret R. Engle</u>	

BUREAU V. 8

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09227

9235

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R.D.1 (Silver Run)				e. STREET ADDRESS Westminster, Md. R.D.1 (Silver Run)			
3. NAME OF DECEASED (Type or print) Emma Catherine Stair				4. DATE OF DEATH Month 9/22/56 Day 19 Year 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/1902	9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months 7 Days 22 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Zepp				14. MOTHER'S MAIDEN NAME Mary Catherine Wantz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-2135		17. INFORMANT Newton O. Stair Address Newton O. Stair, R.D.1, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardio-vascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 443X DUE TO (c) 443X DUE TO						INTERVAL BETWEEN ONSET AND DEATH 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Sept. 1, 1956 , to Sept. 22, 1956 , that I last saw the deceased alive on Sept. 18, 1956 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leah Abel Maitland				ADDRESS (Street, city or town, state) 50 Maple Avenue Littlestown, Pa.		DATE SIGNED 9/22/56	
PHYSICIAN'S NAME (Type) LEAH ABEL MAITLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/24/56		22c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) (State) Pleasant Valley, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REC'D BY REGISTRAR DATE 9-24-56	
				24b. REGISTRAR'S SIGNATURE Harriet Muller			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

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BUREAU V. S.

SEP 26 1956

RECEIVED

9236

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester Rural			c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Adams Staub				4. DATE OF DEATH Month Day Year September 24 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1880	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Adams Co, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Staub				14. MOTHER'S MAIDEN NAME Mary Elizabeth Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mervin Mr Mervin Staub Manchester, Md. Address P.O. #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 5 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE W. H. Foard				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W. H. Foard M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/56		22c. NAME OF CEMETERY OR CREMATORY Greenwood		22d. LOCATION (City, town, or county) (State) East Berlin, Pa Adams Co	
23. FUNERAL DIRECTOR'S SIGNATURE Frederick Bucher				ADDRESS Hannover Pa			
24a. REC'D BY REGISTRAR Sept 24-56				24b. REGISTRAR'S SIGNATURE Mrs. W. P. Deumer			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

RECEIVED
SEP 26 1956
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9237

CERTIFICATE OF DEATH

Reg. Dist. No.

092294

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
				d. STREET ADDRESS 104 N. Green, St., 2nd fl.			
3. NAME OF DECEASED (Type or print) First George Middle SUCK Last				4. DATE OF DEATH Month September Day 26 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/97	
				9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) West Virginia			
				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Suck				14. MOTHER'S MAIDEN NAME Altie West			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address Springfield Hospital records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) General Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) phrase Chronic brain syndrome associated with alcoholism without qualifying							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 6, 1956 , to September 26 1956 , that I last saw the deceased alive on September 25, 1956 , and that death occurred at 2:07AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.				DATE SIGNED 9/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct 1 1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE WM. COOK Inc. 1215 St. Paul Street				ADDRESS Balto 2		24a. REC'D BY REGISTRAR 1956	
				24b. REGISTRAR'S SIGNATURE C. Harry Hoops			

BUREAU V. S.

OCT 1 1956

RECEIVED

9238

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER, MD.</u>			
c. LENGTH OF STAY IN 1b <u>40 YRS.</u>				d. STREET ADDRESS <u>NEW WINDSOR #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN CHAPEL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STERLING FRANKLIN THOMAS</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 18 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 11, 1906</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REV. ROBT FRANKLIN THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. ADAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>MRS. MARY E. THOMAS, NEW WINDSOR, MD. RD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis - 322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Alcoholism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>One hour</u> <u>3 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9/19</u> , 19 <u>56</u> , to <u>9/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/19</u> , 19 <u>56</u> , and that death occurred at <u>8:19</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. LUTHER BARE</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster, MD.</u> DATE SIGNED <u>9/19/56</u>			
PHYSICIAN'S NAME (Type) <u>S. LUTHER BARE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 21, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. ZIMMER, JR.</u> ADDRESS <u>WESTMINSTER, MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 9-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Bulley</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

MARYLAND

BUREAU V. S.

SEP 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD
9239
CERTIFICATE OF DEATH

09231

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER				c. LENGTH OF STAY IN 1b 15 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WIMEST NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE GUILFORD VEITCH				4. DATE OF DEATH SEPT. 26 19 56			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1869	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE RET.		10b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS L. VEITCH				14. MOTHER'S MAIDEN NAME GERTRUDE WOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT SAMUEL L. VEITCH Address 1463 MANOA RD. PENN WILMIE, PA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial (chr), Nephritis (chr) 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May, 1950 , to Sept 26, 1956 , that I last saw the deceased alive on Sept 25, 1956 , and that death occurred at 4 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.C. Jernette M.D.				ADDRESS (Street, city or town, state) 103 E Main DATE SIGNED			
PHYSICIAN'S NAME (Type) Wm Carl Jernette				Westminster Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 607.1.1956		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		22d. LOCATION (City, town, or county) (State) PIKESVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE ABNARD YSON WESTMINSTER, MD. ADDRESS				24a. REC'D BY REGISTRAR DATE 9-26-56		24b. REGISTRAR'S SIGNATURE Harriet Miller	

BUREAU V. S.

SEP 28 1956

RECEIVED

9240

CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Nursing Home				e. STREET ADDRESS 43 Carroll St.			
3. NAME OF DECEASED (Type or print) First William Middle Harman Last Wardenfelt				4. DATE OF DEATH Month Sept. Day 10 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Farm Owner				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY U S A							
13. FATHER'S NAME Henry Wardenfelt				14. MOTHER'S MAIDEN NAME Elizabeth Frizzell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-28-5340		17. INFORMANT Charles E. Wardenfelt Address Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myasthenia Gravis 744.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 1 year.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Aug 2, 1953 , to Sept 10, 1956 , that I last saw the deceased alive on Sept 10, 1956 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 85 1/2 W. Green St. Westminster, Maryland DATE SIGNED 9/10/56							
ACTUAL SIGNATURE Julius Chepko M.D.							
PHYSICIAN'S NAME (Type) Julius Chepko				85 1/2 W. Green St. Westminster, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-12-56		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City; town, or county) (State) Smallwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR 9-12-56	
				24b. REGISTRAR'S SIGNATURE Harriet Miller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09233

9241

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>19 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>3 Vol 4</u>	
3. NAME OF DECEASED (Type or print) <u>W. Wasoski, Wasoski, Milton</u>		4. DATE OF DEATH <u>Sept. 23 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poland</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>unknown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>immediately</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis e cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July - 1 - 1950</u> , to <u>Sept - 23 - 1956</u> , that I last saw the deceased alive on <u>Sept. 22, 1956</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.		ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>		DATE SIGNED <u>9/23/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 26/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Ozagowski</u>		ADDRESS <u>1930 Eastern Ave</u>	
24a. RECEIVED BY REGISTRAR <u>SEP 26 1956</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Harry</u>	

CERTIFICATE OF DEATH

Form No. 10

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

SEP 26 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09234

9242

Items 8,9: G204 10-2-56:L

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Woods Last Weidman				4. DATE OF DEATH Month September Day 26 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/1870	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jeremiah Woods			14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Springfield Hospital records Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple lung abscesses DUE TO (c) unknown INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dementia Praecox - paranoid type of long standing							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 1, 1950 , to September 26, 1956 , that I last saw the deceased alive on September 26, 1956 , and that death occurred at 1:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Walther H. Sonnenfeldt		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 9/26/56			
PHYSICIAN'S NAME (Type) Walther H. Sonnenfeldt, M.D.		Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept 29/1956		22c. NAME OF CEMETERY OR CREMATORY London Park			
22d. LOCATION (City, town, or county) Balds Md		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Harry Harnack		ADDRESS 4204 Redgewood Circle		24a. REC'D BY REGISTRAR SEP 28 1956			
24b. REGISTRAR'S SIGNATURE C. Harry Wiersa							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

See back for instructions

BUREAU V. R.

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BUREAU V. 3.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9245

CERTIFICATE OF DEATH

09237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henryton</u>		c. LENGTH OF STAY IN 1b <u>829 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Henryton State Hospital</u>		d. STREET ADDRESS <u>736 George Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Lenora</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1905</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Drew</u>		14. MOTHER'S MAIDEN NAME <u>Evers Henry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-28-2580</u>	
17. INFORMANT <u>Patient, Helen L. Williams</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Far advanced bilateral cavitory tuberculosis</u> <u>002 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 10, 1954</u> to <u>Sept. 16, 1956</u> , that I last saw the deceased alive on <u>Sept. 16, 1956</u> , and that death occurred at <u>6.00 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Henryton, Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>T. F. Vestal</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>T. F. Vestal</u> <u>Henryton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>9/19/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Cooper</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>9-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>Albert R. Frankhaus</u>	

RECEIVED
SEP 10 1956
BUREAU V. S.

9244

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				c. LENGTH OF STAY IN 1b <u>5 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 Fair St.</u>				d. STREET ADDRESS <u>29 Fair St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALVERTA JANE WICKS</u>				4. DATE OF DEATH Month Day Year <u>Sept. 29 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24 1889</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home - wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Louisville Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William H. Conway</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Schaeffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Chas. W. Wicks, Westminster, Md.</u>		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer (of stomach)</u> <u>151X</u> DUE TO <u>+ infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Apr - 56</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr 1950</u> , to <u>Sept 29, 1956</u> , that I last saw the deceased alive on <u>Sept 28, 1956</u> , and that death occurred at <u>158 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Jernette</u> M.D.				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>9-29-56</u>			
PHYSICIAN'S NAME (Type) <u>Wm. Carl Jernette</u>				103 E Main			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 1, 56</u>		<u>Deer Park Cemetery</u>		<u>Smallwood Carroll Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Myers, Jr.</u>				ADDRESS <u>Westminster, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 9-30-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Hammond Miles</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. NAME OF DECEASED		12. NAME OF FATHER	
13. NAME OF MOTHER		14. NAME OF SPOUSE	
15. NAME OF CHILDREN		16. NAME OF SIBLINGS	
17. NAME OF OTHER RELATIVES		18. NAME OF OTHER RELATIVES	
19. NAME OF OTHER RELATIVES		20. NAME OF OTHER RELATIVES	
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29. NAME OF OTHER RELATIVES		30. NAME OF OTHER RELATIVES	
31. NAME OF OTHER RELATIVES		32. NAME OF OTHER RELATIVES	
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77. NAME OF OTHER RELATIVES		78. NAME OF OTHER RELATIVES	
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81. NAME OF OTHER RELATIVES		82. NAME OF OTHER RELATIVES	
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89. NAME OF OTHER RELATIVES		90. NAME OF OTHER RELATIVES	
91. NAME OF OTHER RELATIVES		92. NAME OF OTHER RELATIVES	
93. NAME OF OTHER RELATIVES		94. NAME OF OTHER RELATIVES	
95. NAME OF OTHER RELATIVES		96. NAME OF OTHER RELATIVES	
97. NAME OF OTHER RELATIVES		98. NAME OF OTHER RELATIVES	
99. NAME OF OTHER RELATIVES		100. NAME OF OTHER RELATIVES	

RECEIVED
OCT 2 1956
BUREAU V. S.

9193

CERTIFICATE OF DEATH

09238

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MID. b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COLLEGE HILL				d. STREET ADDRESS COLLEGE HILL			
3. NAME OF DECEASED (Type or print) LOLA First MAY Middle WOOD Last				4. DATE OF DEATH SEPT. 28 Month 1956 Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1864		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) V.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ZACHARY TAYLOR WOOD				14. MOTHER'S MAIDEN NAME LOLA MACUBIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address COLLEGE HILL LOTTIE MAY GEIMAN WESTMINSTER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral softening DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) valvular heart disease						INTERVAL BETWEEN ONSET AND DEATH 2 yrs 4 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY: Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2, 1956 to Sept 28, 1956 , that I last saw the deceased alive on July 12, 1956 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Hill, Westminster, Md. DATE SIGNED 9/28/56							
ACTUAL SIGNATURE E. REESE WILKENS		PHYSICIAN'S NAME (Type) E. REESE WILKENS					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-2-1956		22c. NAME OF CEMETERY OR CREMATORY MEADOWBRANCH CEM. WESTMINSTER, MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Bankard Son Westminster 2				ADDRESS Westminster 2		24a. REC'D BY REGISTRAR DATE 10-3-56	
				24b. REGISTRAR'S SIGNATURE James Mills			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - JANUARY 1956

Form 10-56

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "65 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "1910"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. MARITAL STATUS [Faint text, possibly "Married"]</p>		<p>8. DATE OF MARRIAGE [Faint text, possibly "1935"]</p>	
<p>9. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>10. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>	
<p>11. MEDICAL HISTORY [Faint text, possibly "Hypertension"]</p>		<p>12. PRESENT ILLNESS [Faint text, possibly "Chest pain"]</p>	
<p>13. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>14. PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]</p>	
<p>15. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>16. SIGNATURE OF REGISTRAR [Faint signature]</p>	

BUREAU V. R.

OCT 8 1956

RECEIVED

9246

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>6 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1932 N. Patterson Park Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>ZUEBERT</u> Last <u>ZUEBERT</u>				4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) yrs. <u>60 ?</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Springfield Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular dis.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Years.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis.</u> <u>Years.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with arteriosclerosis.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 14, 1956</u> , to <u>September 20, 1956</u> , that I last saw the deceased alive on <u>September 20, 1956</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Agustin del Campo</u>				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>		DATE SIGNED <u>9/20/56</u>	
PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				<u>Sykesville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>September 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmichael</u>		22d. LOCATION (City, town, or county) (State) <u>Chesapeake, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leo G. Seabrook</u>				ADDRESS <u>1932 N. Patterson Park Ave.</u>		24a. REC'D BY REGISTRAR <u>Sept 24 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>E. J. [Signature]</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON

SEP 26 1956

RECEIVED